

APPENDIX 9
PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: _____

Address: _____

Medicaid Number: _____ Phone #: _____

Contact Person: _____

Type of Service(s) Provided: _____

Estimated Monthly Medicaid Claims Filed: _____

1. Do you currently submit your Medicaid claims on paper? ☐ YES ☐ NO

2. Are your Medicaid claims computer generated on paper? ☐ YES ☐ NO

3. Do you use a billing service? ☐ YES ☐ NO

If the answer is YES to #2 or #3, please complete the following:

Name: _____ Contact: _____

Address: _____ Phone #: _____

4. Do you have an in-house computer system? ☐ YES ☐ NO

If YES, type of computer system:

a. Large main frame (e.g., IBM 360, Burroughs 3800)	Manufacturer: _____ Model #: _____
b. Mini-Computer (e.g., IBM System 34, or 36 TI 990)	Manufacturer: _____ Model #: _____
c. Micro-Computer (e.g., IBM PC, COMPAQ, TRS 1000)	Manufacturer: _____ Model #: _____

5. Please send the paperless claims manual for:

☐ magnetic tape submission

☐ telephone transmission (EDS free software) ☐ 3-1/2" ☐ 5-1/4"

☐ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009